Positively CHIROPRACTIC
PREGNANCY, FAMILY, PEDIATRIC

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Welcome to **Positively Chiropractic.** Our mission is to restore and maximize health for all families and individuals in our community. We're honored to have the opportunity to take GREAT care of you here!

New Practice Member Information

Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Cell: _____ Email: _____
Date of Birth: _____ Current Age: _____ Gender or Preference:_____
Marital Status: _____ Spouse/Partner's Name: _____
Are you Pregnant? _____ Name and age of Children: _____
Occupation: _____ Current Employer: _____
How did you hear about our office? _____
Emergency Contact: _____ Relationship: _____Phone #: _____

Reason for Seeking Care

*Please briefly describe the area of chief complaint(s). Intensity scale: 0=None 10=unbearable. *If you have no complaints, and are seeking chiropractic care for wellness, indicate "none" below.*

Area	Duration	Pain Scale	Describe Pain
1. _____	_____	0 1 2 3 4 5 6 7 8 9 10	Sharp Dull Ache
2. _____	_____	0 1 2 3 4 5 6 7 8 9 10	Sharp Dull Ache
3. _____	_____	0 1 2 3 4 5 6 7 8 9 10	Sharp Dull Ache

Based on your complaint

Did any of your complaints begin with an injury? Which ones?
_____

What makes it worse? (Sitting, standing, moving) _____

What makes it better? _____
Who else have you seen for this? *None* *Chiropractor* *MD* *Other* If you answered yes, who/when?
_____

Current Dysfunction

Please indicate which of the following body signals you have experienced or are currently experiencing.

- ☐ Acid Reflux/Heartburn
- ☐ Allergies/Sinus Issues
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bed Wetting
- ☐ Blurred Vision
- ☐ Cancer
- ☐ Cardiac Conditions
- ☐ Cold Feet/Hands
- ☐ Constipation
- ☐ Depression
- ☐ Diabetes
- ☐ Disc Problems
- ☐ Dizziness
- ☐ Ear Infections
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fatigue
- ☐ Gall Bladder Trouble
- ☐ Headaches/Migraines
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Hip Pain
- ☐ Irritable Bowel
- ☐ Indigestion
- ☐ Jaw Pain/TMJ
- ☐ Kidney Condition/Disease
- ☐ Liver Disease
- ☐ Loss of Balance
- ☐ Loss of Smell
- ☐ Low-back Pain
- ☐ Lupus
- ☐ Memory Loss
- ☐ Menstrual Irregularity
- ☐ Mid-back Pain
- ☐ Nausea
- ☐ Neck Pain
- ☐ Nervousness
- ☐ Numbness in Arms/Hands
- ☐ Numbness in Leg/Feet
- ☐ Pain in Legs/Feet
- ☐ Pins/Needles Arms/Hands
- ☐ Pins/Needles Legs/Feet
- ☐ Prostate Trouble
- ☐ Ringing in Ears
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Shoulder/Arm Pain
- ☐ Stiffness
- ☐ Stomach Condition
- ☐ Stroke
- ☐ Swollen Ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Ulcers
- ☐ Vertigo
- ☐ Other_____

Physical, Chemical, Emotional Stressors

Stress that occurs in our lifetime impacts our health. To better take care of you, it is important for us to understand the physical, chemical, and emotional stresses you have endured over time.

Physical *(Circle One)*

Which is your typical work week? *Sitting* *Standing* *Walking* *Lifting*

Have you experienced the following? *Falls* *Surgeries* *Fractures* *Injuries* *Hospitalizations*

Describe your sleep patterns. *Side* *Back* *Stomach* Duration: *<4 Hours* *5-8 Hours* *8+ Hours*

Have you been in any auto accidents? *Yes* *No* Date of Accident: _____ Injuries: _____

Describe the accident: _____

Chemical *(Circle One)*

Have you been vaccinated as a child or adult? *Yes/No* Last One Received? _____ Bad Reactions?_____

Do you: *Smoke Tabacco* *Use Recreational Drugs* *Drink Alcohol*

Do you consume: *Fried Foods* *Soda/Pop* *Dairy* *Caffeine* *Sweeteners*

Emotional *(Circle One)*

Do you consider yourself: *Overstressed* *Lonely* *Anxious* *Depressed*

Have you experienced: *Loss of a Loved One* *Divorce* *Loss of a Job* If so, when? _____

Health History

Please list all medications you are taking (if more than 4, please attach a list to this paperwork):

Medication: _____ Reason: _____ Dosage: _____
Medication: _____ Reason: _____ Dosage: _____
Medication: _____ Reason: _____ Dosage: _____
Medication: _____ Reason: _____ Dosage: _____

Please list any broken bones, surgeries, auto accidents or hospitalizations you have had:

Incident: _____ Date: _____
Incident: _____ Date: _____
Incident: _____ Date: _____
Incident: _____ Date: _____

Positive Lifestyle Habits

Please answer the questions below by describing or marking the answers that apply to your current lifestyle.

How often do you exercise each week? _____

Strength Training Swimming Biking Walking Yoga/Pilates Sports Other:_____

Have you ever been to a chiropractor before? **Yes/No** If yes, where?_____

What are your goals for chiropractic care? Remove Pain Restore Health Full Health Potential
Other Health Goals: _____

Other Care Providers

Our office seeks to provide the best care for you. We do that by connecting with your other providers to find solutions for your health. Please fill out the information below for providers that you currently see on a regular basis.

MD or Family Physician: _____ Location: _____
Mental Health Doc: _____ Location: _____
Physical Therapist: _____ Location: _____
Massage Therapist: _____ Location: _____

HIPPA - Release of Information - Consent to Care - Payment -

Consent to Care : When a person seeks chiropractic healthcare and we accept a patient for such care it is essential for both to be working towards the same objective. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. If you desire advice, diagnosis, or treatment for abnormal findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Our only treatment is specific adjusting to correct vertebral subluxations. I authorize PC to use my physical address to contact me with cards, newsletters, and financial or health-related information. I authorize PC to leave a detailed message on my home phone answering machine, cell phone voicemail, or email regarding medical treatment, care, appointments, missed appointment notifications, test results, office events, or financial information. I authorize PC to leave a message with anyone who answers my phone. I authorize PC to use my name, photograph, video/audio recording, or my written testimonial on marketing materials such as but not limited to brochures, website, bulletin board, social media accounts, and ads in print media. I authorize Positively Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. *Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations per request when scheduled ahead of time.*

Payment : I authorize and request payment of insurance benefits directly to Positively Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I acknowledge that this assignment of benefits **does not in any way relieve me of payment liability, and that I will remain financially responsible to Positively Chiropractic for any and all services I receive at this office for both insurance claims and out of pocket adjustments.** I also understand any sum of money paid under assignment by any insurance shall be credited to my account, and **I shall be personally liable for any and all of the unpaid balances to Positively Chiropractic for adjustments billed to insurance or out of pocket. All professional services rendered are charged to the patient. I understand that I am financially responsible for charges not covered by this assignment.**

Privacy Pledge/ HIPPA : We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information but not without your permission first. A copy of our Privacy Practices is provided and we encourage you to read it and request your own copy if you would like one.

"I understand and comply with the information provided above for information pertaining to but not limited to patient authorization, consent to care, payment and our privacy pledge. By signing this form, I understand that I'm giving Positively Chiropractic permission to collect payment immediately for any and all services rendered. I understand that I am giving Positively Chiropractic permission to care for me or my minor. I understand that there may be risks associated with Chiropractic care, and I do hereby authorize the doctors and staff of Positively Chiropractic to administer such care that is needed.

Printed Name: _____

Signature: _____ **Date:** _____

Authorized Provider Representation: _____ Date: _____

Consent to Care for a Minor

If this health intake form is for a minor/child, please fill out and sign below.

Name of patient who is a minor/child: _____ Date of birth of minor: _____

"I understand that risks are associated with Chiropractic care and I do hereby authorize the doctors at Positively Chiropractic, and all Positively Chiropractic staff to administer such care that is necessary for _____ (minor's full name)'s particular case. This care may include consultation, examination, chiropractic adjustments, or any other procedure pertaining to my minor/child's chiropractic care in this office. As of this date, I have legal right to select and authorize healthcare services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Positively Chiropractic."

Guardian Signature: _____ **Date:** _____ **Relationship to minor:** _____